MARYLAND
Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

A Quality Improvement Plan for Maryland's Public Health Services

Version 1.1

Maryland Department of Health
Public Health Services Division

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Chapter 1. Introduction & Table of Contents

Introduction

Quality improvement is a deliberate and defined improvement process that is focused on activities that are responsive to community needs and improving population health.

In short, *how can we do better?*

A quality improvement plan paves the road to doing better for the division of Public Health Services (henceforth called Public Health) in Maryland's Department of Health.

The quality improvement plan seeks to build quality improvement infrastructure that enables Maryland to establish, manage, deploy, and monitor quality throughout the organization. Aligned with organizational policies and direction, this plan identifies processes and activities that will be put into place to ensure that quality services are provided consistently.

This plan conforms to the standards and measures regarding quality improvement set forth by the Public Health Accreditation Board. Refer to Appendix's PHAB Guidance.

Accordingly, guidance for standard 9.2 outlines this plan.[i]

Table of Contents

What's changed since the last version of this plan?

Version 1.1 (7/31/2017)

1. New MDH branding replaced DHMH branding.
2. Content added to work plan to update progress.
3. Content added to communications action plan to update progress.

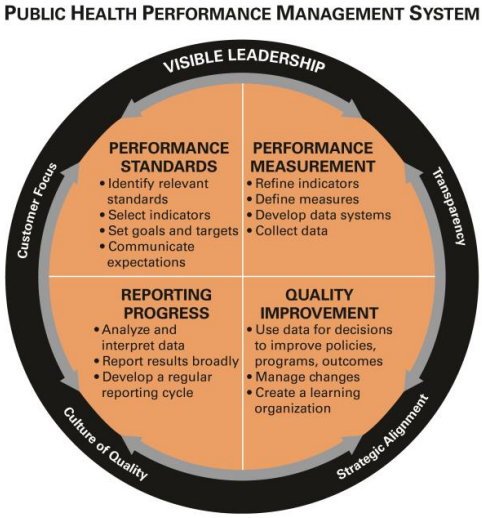
Version 1.0 (5/31/2017)

1. Development and publication of plan.

CHANGING Maryland *for the Better*

Chapter 2. Key Terms

PHAB 9.2 related guidance: Key quality terms[ii] to create a common vocabulary and a clear, consistent message.



Quality improvement is one part of performance management. Performance Management is a systematic process which helps an organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making. In practice, performance management often means actively using data to improve performance, including the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results.

Quality improvement is the establishment of a program or process to manage change and achieve improvement in public health policies, programs, or infrastructure based on performance standards, measures, and reports. Below are related key terms:

Accreditation[ii]

The development and acceptance of a set of national public health department (HD) accreditation standards; the development and acceptance of a standardized process to measure HD performance against those standards; the periodic issuance of recognition for HD that meet a specified set of national accreditation standards; and the periodic review, refining, and updating of the national public HD accreditation standards and the process for measuring and awarding accreditation recognition.

Maryland's Public Health Services

Maryland's Department of Health (MDH), Division of Public Health Services. Public Health Services promotes and improves the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement.

Plan-Do-Study-Act (PDSA)[ii]

PDSA is an iterative four-stage problem-solving model for improving a process or carrying out change. Three fundamental questions associated with PDSA are: what are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?

Quality Improvement (QI)[ii]

In short, how can we do better? The use of a deliberate and defined improvement process that is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.

QI Plan

Maryland Public Health Services' roadmap to doing better. Updated annually.

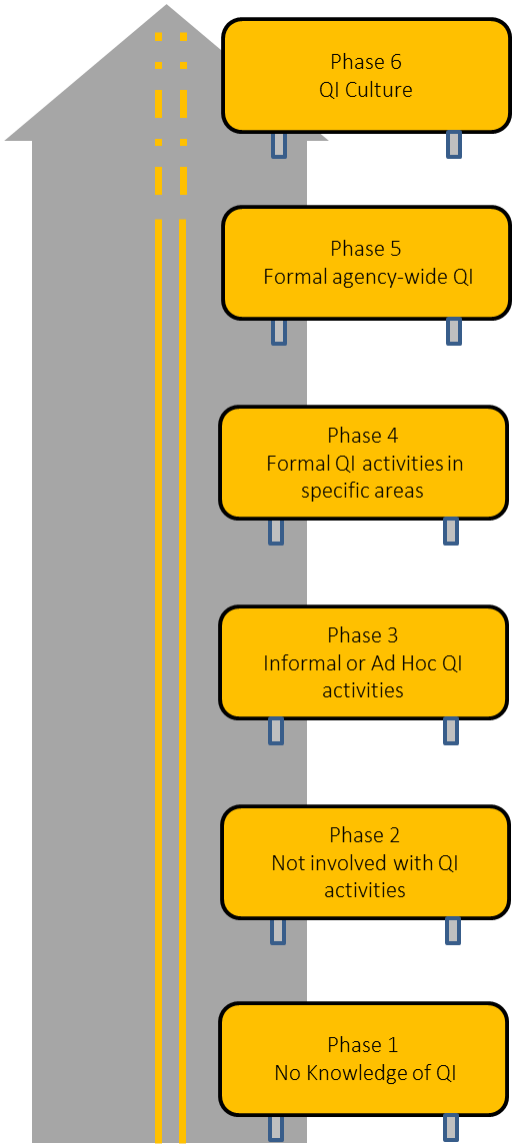
Chapter 3. Culture of Quality

PHAB 9.2 related guidance: Culture of quality and the desired future state of quality in the organization.

Maryland's Public Health Services seeks to grow a culture of QI. We follow a framework provided by the National Association of County and City Health Officials (NACCHO) called, "Roadmap to a Culture of Quality Improvement." [iii]

Phase/ Exit 6 of the Roadmap describes what we ultimately hope to work toward with QI culture:

A mature culture of quality is exhibited when quality improvement is fully embedded into the way we do business, across all levels, departments, and programs. Leadership and staff are fully committed to quality, and results of quality improvement efforts are communicated internally and externally. Even if leadership changes, the basics of QI are so ingrained in staff that they seek out the root cause of problems. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives. [iii]



Desired future state of quality

To advance towards a mature QI culture, we will first assess[iv] our state of QI culture. Refer to **Appendix's QI Maturity Tool & Rubric**. The Roadmap will help interpret assessment findings.

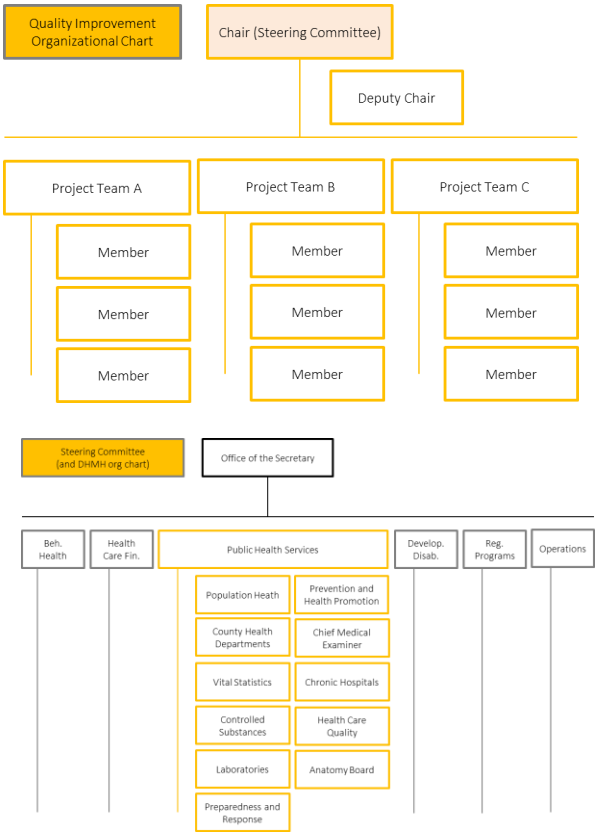
We will gauge our current and desired future states[v] of quality using the Roadmap's "characteristics." Refer to **Appendix's Current State of Quality**.

Chapter 4. Structure

PHAB 9.2 related guidance:

- *9.2.1 - Key elements of the quality improvement effort's structure, for example:*
  - *Organization structure*
  - *Membership and rotation*
  - *Roles and responsibilities*
  - *Staffing and administrative support*
  - *Budget and resource allocation*

Organization Structure[vi,vii,viii]



The Quality Improvement Council comprises of: Chair (steering committee), Deputy Chair, and members. While the steering committee guides the QI Plan and members execute the work plan, the Deputy Chairs manages logistics and operations.

Chair of the QI Council takes form of a steering committee. The steering committee cultivates a foundation for success for QI. The steering committee comprises of:

- Division of Public Health Services, which facilitates improvement culture.
  - Deputy Secretary's office
  - Administration Directors

Deputy Chairs facilitate communication between the chair/ steering committee and QI Council members, as well as operate the QI Council. The Deputy Chair comprises of:

- Office of Performance Improvement
- Quality Improvement Specialist

QI Council members guide us to achieve our desired state of quality by supporting QI activities. The QI Council's efforts are not intended to replace the QI and program evaluation responsibilities of program leadership. The QI Council Charter organizes the QI Council. The QI Council members develop and implement the work plan. QI Council members comprise of:

- Representatives from most Public Health Services administrations

Staffing, administrative support, budget, and resource allocation

Quality improvement is currently budgeted within federal grants for subject-matter specific projects. The QI Specialist is supported through Federal PHHS Block Grant funds.

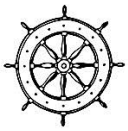
Rotation [v]

From our governing entity to frontline staff, everyone may play a role in QI. Staff who express interest in learning about QI may sign up as QI Advocates; they remain a QI Advocate however long they choose. QI Advocates who are ready to gain skills in QI may apply for the QI Council; QI Council members rotate every 2 years. Administrations may opt-out once per 4 years.

Roles, responsibilities, and membership [vii,ix,v,x,xi,xii]

The table below lists each role and its responsibilities and membership. For detailed information on the QI Council and their work plan, refer to Appendix's QI Council Charter.

What role may I play?

Role	How can we do better?	Responsibilities	How do I become a member?
Staff 	"I do not yet see my role in doing better."	Take QI training.	All staff eligible.
QI Advocate 	"I want to learn more about my role in doing better."	Take QI training. Learn about QI concepts and practices. Tell others about quality improvement.	All staff eligible. Sign up for a listserv.
QI Council Member 	"I am preparing skills for doing better." "I am taking action to do better."	Leadership commitment QI infrastructure (that aligns with other efforts) Employee empowerment (e.g., QI Training) Customer focus Teamwork and collaboration Continuous process improvement	Members will be selected from among Public Health QI Advocate applicants. Apply.
QI Steering Committee 	"I am maintaining a culture of doing better."	Create urgency and vision. Create a powerful team. Communicate your vision. Empower staff.	Limited to: Deputy Secretary of Public Health's office & Administration Directors

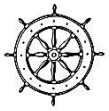
Chapter 5. Training

PHAB 9.2 related guidance: Types of quality improvement training available and conducted within the organization for example:

- *New employee orientation presentation materials*
- *Introductory online course for all staff*
- *Advanced training for lead QI staff*
- *Continuing staff training on QI*
- *Other training as needed – position-specific QI training (Epidemiology, infection control, etc.)*

All staff are encouraged to learn about QI concepts and practices. Quality improvement training will be provided on a regular basis and ultimately integrated into certain aspects of new employee onboarding and orientation as recommended by the Public Health Services Workforce Development Plan. Resources will determine topics offered and frequency of offerings.

Training Levels

	Orientation	Beginner[xiii]	Electives	Advanced
Mode	⋘Online ⋒ In person	⋘Online ⋒ In person	⋘Online ⋒ In person	⋒ In person
Duration	15-30 mins.	50 mins.	Variable.	2 days.
Examples	"Introduction to QI – Kansas" (online) "QI- An Orientation" (in person)	OSU's Continuing Quality Improvement: Fundamentals	OSU's Continuing Quality Improvement: Tool Time	Public Health Foundation's Quality Improvement Basics
Staff 	Suggested, if resources permit.			
QI Advocate 	Suggested, if resources permit.	Suggested, if resources permit.	Suggested, if resources permit.	
QI Council 	Suggested, if resources permit.	Suggested, if resources permit.	Suggested, if resources permit.	Required.
QI Steering Committee 	Suggested, if resources permit.	Suggested, if resources permit.	Suggested, if resources permit.	Suggested, if resources permit.

Chapter 6. Work Plan

PHAB 9.2 related guidance:

- *The health department's approach to how the quality improvement plan is monitored: data are collected and analyzed, progress reported toward achieving stated goals and objectives, and actions taken to make improvements based on progress reports and ongoing data monitoring and analysis.*
- *Process to assess the effectiveness of the quality improvement plan and activities, which may include:*
    - *Review of the process and the progress toward achieving goals and objectives*
    - *Efficiencies and effectiveness obtained and lessons learned*
    - *Customer/stakeholder satisfaction with services and programs*
    - *Description of how reports on progress were used to revise and update the quality improvement plan*

Goals, objectives, and measures with time-framed targets [vii,v,xiv,iii]

After determining our current state of quality, we will then set goals and objectives to get to our desired state of quality. These will be outlined in a work plan. For detailed information, refer to Appendix's Work Plan. Our goals are organized by Roadmap themes:

- Leadership commitment
- QI infrastructure
- Employee empowerment and commitment
- Customer focus
- Teamwork and collaboration
- Continuous process improvement

Monitor [v]

Periodic meetings will take place to monitor the QI Plan. After each meeting, participants will produce a meeting summary that includes an update on the work plan progress. Refer to Appendix's Work Plan.

Evaluate[xv,xvi]

At the end of the term or by the last deadline listed on the Work Plan, members will:

1. Evaluate Work Plan on regular basis — Refer to Appendix's Work Plan.
2. On an annual basis, the QI Council (via the QI Specialist) will review sustainability of the QI program by employing a checklist. Refer to Appendix's Plan Sustainability Checklist.
3. Share lessons learned with leadership and staff.

Chapter 7: Projects

PHAB 9.2 related guidance:

- *9.2.1 Project identification, alignment with strategic plan and initiation process:*
  - *Describe and demonstrate how improvement areas are identified and how they are prioritized for project activity*
  - *Describe and demonstrate how the improvement projects align with the health department's strategic vision/mission*
- *9.2.1 Process to assess the effectiveness of the quality improvement plan and activities, which may include:*
  - *Review of the process and the progress toward achieving goals and objectives*
  - *Efficiencies and effectiveness obtained and lessons learned*
  - *Customer/stakeholder satisfaction with services and programs*
  - *Description of how reports on progress were used to revise and update the quality improvement plan*
- *9.2.2 Documentation must demonstrate ongoing use of an improvement model, including showing the tools and techniques used during application of the process improvement model. Documentation must also describe: actions taken, improvement practices and interventions, data collection tools and analysis, progress reports, evaluation methods, and other activities and products that resulted from implementation of the plan.*

Identify project[xvii,xviii,xix]

Improvement project ideas may impact a program, office, or may be cross-cutting across administrations. Improvement areas may be identified by, but not limited to, the strategies below. Refer to Appendix's Technical Assistance Request.

a. Staff submits project ideas; OR
b. QI Council or other entity identifies improvement area(s) in data from:
   - Strategic Plan - Public Health Services applies QI as one of four lenses that informs the strategies put forth by the Strategic Plan; or
   - Performance Management System - The Performance Management System (known as Managing for Results) will both identify potential QI projects and measure subsequent improvements; or
   - Workforce Development Needs Assessment – In the workforce development plan, PDSA is used to address needs; additionally, this plan supports QI training; or
   - State Health Improvement Process - This is a potential data source to identify QI projects.

Prioritize[xx,xxi,xxii]

Improvement projects will be prioritized by criteria below. Refer to Appendix's Prioritization Matrix.

a. PDSA ready (e.g., stable process, opportunity exists to influence change, measurable results)
b. Essential service (e.g., legislative mandate, accreditation, strategic plan, SHIP)
c. Resources required
d. Public health impact
e. Customer impact

Initiate

Projects will be initiated using the Appendix's Project Packet – Project Charter.

Monitoring[v]

Periodic meetings will take place to monitor the QI projects.

1. Each meeting needs to produce a meeting summary.
2. Project activities will be captured in Appendix's Project Packet – Project Tracker.

Evaluate[xxiii,xxiv]

At the completion of a QI project, teams will:

1. Evaluate QI project — Refer to Appendix's Project Packet – Project Tracker.
2. Summarize activity through a Storyboard. Refer to Appendix's Project Packet - Storyboard.

Chapter 8. Communication

PHAB 9.2 related guidance:

- *Measure 9.2.1- Regular communication of quality improvement activities conducted in the health department through such mechanisms as:*
  - *Quality electronic newsletter*
  - *Story board displayed publicly*
  - *Board of Health meeting minutes*
  - *Quality Council meeting minutes*
  - *Staff meeting updates*

The QI Council will update a "Communications Plan." This plan is a free-standing document, not found in this QI Plan. The Communications Plan outlines P.O.S.T method application, communication tools we use, branding guide, guidelines for engaging, staffing and implementation, monitoring and evaluation, future directions, and action plan. On an annual basis, the QI Council will complete the following communication activities (at minimum):

Event	Information/ Content	Potential Tools
Recruitment	Council Recruitment	Website QI Advocate Listserv Council Meeting PHS Directors Meeting Event/ Other Meeting Email Phone call
Letters of invitation	Formal invitation that person was selected to become QI Council member	Email Phone call
QI Council Announcement	Formal announcement of QI council roster	Website QI Advocate Listserv PHS Directors Meeting Event/ Other Meeting
Meeting - Inaugural	Activities: 1) how projects were identified and prioritized. 2) Finalized QI Plan	Website QI Advocate listserv PHS Directors Meeting Event/ Other meeting Report SHIP Newsletter
Meeting - QI Training	Knowledge – QI Tools	QI Advocate listserv PHS Directors Meeting Event/ Other meeting
Meeting - Mid Year check in	Activities – Progress reports	Website QI Advocate listserv PHS Directors Meeting Event/ Other meeting Report SHIP Newsletter
Meeting - End of the year	Activities – Annual reports Best practices – Story boards	Website QI Advocate listserv PHS Directors Meeting Event/ Other meeting Report SHIP Newsletter

Appendix

Public Health Accreditation Board (PHAB) guidance

Measure 9.2.1 A Established quality improvement program based on organizational policies and direction

The purpose of this measure is to assess the health department's efforts to develop a quality improvement program that is integrated into all programmatic and operational aspects of the organization.

Significance: To make and sustain quality improvement gains, a sound quality improvement infrastructure is needed. Part of creating this infrastructure involves writing, updating, and implementing a health department quality improvement plan. This plan is guided by the health department's policies and strategic direction found in its mission and vision statements, in its strategic plan, and in its health improvement plan.

The health department must provide a quality improvement plan. The plan must address:

- *Key quality terms to create a common vocabulary and a clear, consistent message.*
- *Culture of quality and the desired future state of quality in the organization.*
- *Key elements of the quality improvement effort's structure, for example:*
  - *Organization structure*
  - *Membership and rotation*
  - *Roles and responsibilities*
  - *Staffing and administrative support*
  - *Budget and resource allocation*
- *Types of quality improvement training available and conducted within the organization for example:*
  - *New employee orientation presentation materials*
  - *Introductory online course for all staff*
  - *Advanced training for lead QI staff*
  - *Continuing staff training on QI*
  - *Other training as needed – position-specific QI training (MCH, Epidemiology, infection control, etc.)*
- *Project identification, alignment with strategic plan and initiation process:*
  - *Describe and demonstrate how improvement areas are identified and how they are prioritized for project activity*
  - *Describe and demonstrate how the improvement projects align with the health department's strategic vision/mission*
- *Quality improvement goals, objectives, and measures with time-framed targets:*
  - *Define the performance measures to be achieved.*
  - *For each objective in the plan, list the person(s) responsible (an individual or team) and time frames associated with targets*
  - *Identify the activities or projects associated with each objective.*

- *The health department's approach to how the quality improvement plan is monitored: data are collected and analyzed, progress reported toward achieving stated goals and objectives, and actions taken to make improvements based on progress reports and ongoing data monitoring and analysis.*
- *Regular communication of quality improvement activities conducted in the health department through such mechanisms as:*
  - *Quality electronic newsletter*
  - *Story board displayed publicly*
  - *Board of Health meeting minutes*
  - *Quality Council meeting minutes*
  - *Staff meeting updates*
- *Process to assess the effectiveness of the quality improvement plan and activities, which may include:*
  - *Review of the process and the progress toward achieving goals and objectives*

- *Efficiencies and effectiveness obtained and lessons learned*
- *Customer/stakeholder satisfaction with services and programs*
- *Description of how reports on progress were used to revise and update the quality improvement plan*

Measure 9.2.2A Implemented quality improvement activities

The purpose of this measure is to assess the health department's use of quality improvement to improve processes, programs, and interventions.

It takes practice to effectively use the quality improvement plan to improve processes, programs, and interventions. Staff benefit from seeing the plan put into action and receiving regular feedback on progress toward achieving stated objectives, as well as on how well they have executed their respective roles and responsibilities.

1. Quality improvement activities based on the Quality Improvement Plan
The health department must document implementation of quality improvement activities and the health department's application of its process improvement model. Examples must demonstrate:

- *how staff problem-solved and planned the improvement,*
- *how staff selected the problem/process to address and described the improvement opportunity,*
- *how they described the current process surrounding the identified improvement opportunity,*
- *how they determined all possible causes of the problem and agreed on contributing factors and root cause(s),*
- *how they developed a solution and action plan, including time-framed targets for improvement,*
- *what the staff did to implement the solution or process change, and*
- *how staff reviewed and evaluated the result of the change, and how they reflected and acted on what they learned.*

Documentation must demonstrate ongoing use of an improvement model, including showing the tools and techniques used during application of the process improvement model. Documentation must also describe: actions taken, improvement practices and interventions, data collection tools and analysis, progress reports, evaluation methods, and other activities and products that resulted from implementation of the plan.

Documentation could be, for example, quality improvement project work plans or storyboards that identify achievement of objectives and include evidence of action and follow-up.

2. Staff participation in quality improvement activities based on the Quality Improvement Plan.
The health department must document how staff were involved in the implementation of the plan, worked on improvement interventions or projects, and/or served on a quality team that oversees the health department's improvement efforts. Documentation could be, for example minutes, memos, reports, or committee or project responsibilities listings.

Quality Improvement Assessment

Maturity Tool & Rubric

Introduction

The QI maturity tool measures quality improvement (QI) maturity.

This is 1 of 2 steps of a process to describe our current and desired future states of quality.

Instructions

1. Answer each question by selecting one response.
2. Calculate the overall QI maturity score.
    a. Value of each response
        i. 1 = I don't know
        ii. 2 = Disagree/ Strongly Disagree
        iii. 3 = Neutral
        iv. 4 = Strongly Agree/ Agree
    b. Respondents
        i. Individual = calculate average (Responses values / 10)
        ii. Multiple = calculate median
3. Continue to "Current State of Quality."

Learn more about this tool

These ten measures represent a subset of a much more extensive 37-item survey developed, tested, and administered nationally to top public health officials as a way to measure the QI maturity of individual health departments.

For more information: Joly BM, Booth M, Mittal P, et al. (2012). Measuring quality improvement in public health: the development and psychometric testing of a QI Maturity Tool. *Eval Health Prof 35*(2), 119-47. Learn more from Minnesota Public Health Research to Action Network and Robert Wood Johnson Foundation.

See next page for findings on QI maturity score.

Findings on quality improvement maturity
Date administered: July 31, 2016

	Median Response		
Statement	**2016 PHS (2016 QI Council)**	**2017 PHS (2017 QI Council)**	**2018 PHS (2018 QI Council)**
1. Staff members are routinely asked to contribute decisions.	2	4	#
2. The leaders are trained in basic methods for evaluating and improving quality, such as "Plan-Do-Study-Act."	2	1.5	#
3. Job descriptions for many individuals responsible for programs and services include specific responsibilities related to measuring and improving quality.	2	2.5	#
4. There is a quality improvement plan.	2	1	#
5. Customer satisfaction information is routinely used by many individuals responsible for programs and services.	2	2.5	#
6. When trying to facilitate change, staff has the authority to work within and across program boundaries.	2	3	#
7. The key decision makers believe quality improvement is very important.	2	4	#
8. We currently have a pervasive culture that focuses on continuous quality improvement.	2	3	#
9. We currently have aligned our commitment to quality with most of our efforts, policies, and plans.	2	3.5	#
10. We currently have a high level of capacity to engage in quality improvement efforts.	2	2.5	#
Total	2	2.75	#

Key	
I don't know	1
Disagree	2
Neutral	3
Agree	4

Current State of Quality

Introduction

The QI maturity tool measures quality improvement (QI) maturity. The QI maturity score corresponds to the *Roadmap to an Organizational Culture of Quality Improvement* produced by the National Association of County and City Health Officials (NACCHO).

This is 2 of 2 steps of a process to describe our current and desired future states of quality.

Instructions

1. After completing the QI maturity tool, find QI maturity score in table below.
2. Match QI maturity score to NACCHO Roadmap phase.
3. To identify current state of quality, go to identified phase # in NACCHO Roadmap.
4. Transcribe phase's "human characteristics" and "process characteristics" to describe current state.

Key		
QI Maturity Score	**Description**	**NACCHO Roadmap Phases**
0-2.9	Low QI (no knowledge, not involved, starting to get involved)	1,2
3.0-3.9	Medium QI (ad hoc QI)	3,4
4.0+	High QI (Borderline formal QI, formal QI, QI Culture)	5,6

Learn more about this tool

The National Association of County and City Health Officials (NACCHO) convened LHD staff responsible for leading QI efforts in their agencies across the country, as well as QI consultants who have worked with LHDs. These experts discussed the various points along a spectrum regarding the uptake of QI in LHDs and strategies to move toward a culture of QI. As a result of this meeting in April 2011, the foundation for this Roadmap to a Culture of Quality (the Roadmap) was built, based on real experiences of practitioners in the field. Learn more here: http://qiroadmap.org/culture-to-qi/

See next page for findings on the current state of quality.

Findings on the current state of quality Date administered: December 14, 2016			
State	**Phase**	**Human characteristics**	**Process Characteristics**
Current	2 Not involved with QI activities	• Leaders understand and staff are beginning to understand QI concepts and their link to LHD practices. • Leadership has little or no expectations of staff to engage in QI. • Staff may view QI as a trend or temporary activity. • Resentment among staff around the use of QI may be building (i.e., fear of being punished, worry about additional work). • Very few training opportunities exist for staff. • Very few QI Advocates exist.	• Problems are randomly or inconsistently addressed. • Leadership and staff do not know where or how to access data. • Decisions are made without use of data or evidence base. • Simple, informal elements of QI exist (e.g., evaluation activities, some data collection). • Resources and staff time allocated for QI are very limited. • Redundancies and variations in processes are common.
Short term	3 Informal or Ad Hoc QI Activities	• Staff infrequently share lessons-learned. • Staff may view QI as an added responsibility. • Staff are anxious about implementing QI incorrectly or uncovering negative performance. • Staff may be frustrated if efforts do not result in immediate improvement. • Basic QI training and resources are more readily available, but advanced QI training may still be limited. • Some QI champions are able to lead QI projects and mentor staff. • Loss of a QI champion often results in regression.	• QI projects may be occurring only at the administrative staff level or at other isolated times. • Data are still not routinely used in agency operations and decision-making. • Discrete QI projects occur but are likely not fully aligned with formal steps of a QI model (e.g., PDSA). • QI is not aligned with organization's strategic plan or performance data. • Multiple failed attempts to improve through QI projects may exist. • QI efforts are often stalled due to emerging issues (e.g., budget cuts, staff turnover, H1N1 response). • Redundancies and variations in processes still exist.
Long term	6 QI Culture	We ultimately strive towards human and process characteristics described in Phase 6 of NACCHO's Roadmap to a culture of improvement.	

Quality Improvement Council Charter (2017)

Public Health Services
Maryland Department of Health

1. PURPOSE OF THE COUNCIL
   1.1. The Quality Improvement Council is a leadership development program that connects public health advocates with skills to build stronger public health systems. Maryland Public Health Services staff who commit to and are selected for this program are henceforth called "Quality Improvement Council members." Council members who serve a full term will earn demonstrable skills, experience, and an expanded network for enhancing work flow and leadership capacity.
   1.2. The mission of the Quality Improvement Council is to grow a culture of quality improvement in Public Health Services.

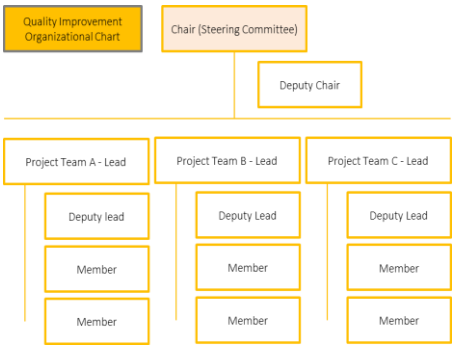
2. DEFINITIONS AND ACRONYMS[1]
   2.1. Accreditation. The development and acceptance of a set of national public health department (HD) accreditation standards; the development and acceptance of a standardized process to measure HD performance against those standards; the periodic issuance of recognition for HD that meet a specified set of national accreditation standards; and the periodic review, refining, and updating of the national public HD accreditation standards and the process for measuring and awarding accreditation recognition.
   2.2. Performance Management. Quality improvement is one part of performance management. Performance Management is a systematic process that helps an organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making. In practice, performance management often means actively using data to improve performance, including the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results.
   2.3. Plan-Do-Study-Act (PDSA). PDSA is an iterative four-stage problem-solving model for improving a process or carrying out change. Three fundamental questions associated with PDSA are: what are we trying to accomplish? How will we know that a change is an improvement? What changes can awe make that will result in improvement?
   2.4. Quality Improvement (QI). The use of a deliberate and defined improvement process that is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.
   2.5. QI Plan. Maryland Public Health Services' roadmap to doing better. Updated annually.

3. OVERSIGHT
   3.1. The QI Steering Committee oversees the QI Council and their work plan. The Steering Committee cultivates a foundation for success for QI. The Steering Committee comprises of

[1] Public Health Accreditation Board. (2013). Acronyms & Glossary of Terms, Version 1.5. Retrieved from: http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf

leadership from the Office of the Secretary and Division of Public Health Services.

4. ORGANIZATION OF QI COUNCIL
   - 4.1. Appointment
     - 4.1.1. The Council shall consist of no less than three (3) and no more than 25 members. A vacancy shall not prevent the Council from conducting business.
     - 4.1.2. Maryland DHMH PHS staff must apply to be considered for the Council. Selection will be based on a set of criteria:
       - 4.1.2.1. Completion of application
       - 4.1.2.2. Staff of Maryland MDH PHS
       - 4.1.2.3. Match in Council goals and applicant interests
       - 4.1.2.4. Diversity of overall Council
     - 4.1.3. The Council recognizes the importance of diversity in membership. The Council will look for representation based on:
       - 4.1.3.1. MDH PHS administration
       - 4.1.3.2. Staffing level (e.g., management, coordinator, administrative support)
     - 4.1.4. Council members will receive a letter of acceptance.
   - 4.2. Requirements
     - 4.2.1. All members of the Council shall serve on a voluntary basis without compensation.
     - 4.2.2. All must maintain employment with MDH PHS.
     - 4.2.3. Council members shall serve for two year terms. This does not preclude any leader from being reappointed. There is no maximum appointment.
     - 4.2.4. Members who receive a letter of acceptance must confirm their role by submitting the QI Advocate pledge.
     - 4.2.5. The Council has the right to remove Council leaders for good cause shown.
     - 4.2.6. Automatic removal results when a member fails to attend a minimum of 75% of Council meetings in a calendar year without reasonable excuse presented in written form and accepted by the Council Chair.
   - 4.3. Rotation
     - 4.3.1. Members of the Council will serve in staggered terms.
   - 4.4. Positions
     - 4.4.1. The positions within the Council are flexible and scalable to needs and resources. The Chair may evaluate needs and make decisions accordingly.
     - 4.4.2. The Chair and Deputy Chair positions will be filled by Steering Committee members. The Steering Committee has oversight of the Council.
     - 4.4.3. Each position's responsibilities will be outlined by each Council.



5. MEETINGS
   - 5.1. A quorum for the purpose of holding a Council full group meeting shall consist of not less than three (3) Council members.
   - 5.2. As schedules and space permits, Council meetings will be held at the Maryland MDH Preston Street campus. Meetings should be attended in person.
   - 5.3. Council meetings shall be held at a frequency agreed upon by the Council members.
   - 5.4. Written notice of the starting time, date, and location of each Council meeting shall be delivered, mailed, or electronically sent to each member no less than seven (7) calendar days

before each meeting.

6. VOTING AND DECISION MAKING
   6.1. Council members should seek consensus first.
   6.2. If consensus cannot be reached, the Council shall cast votes. Each member has one vote per decision. Voting can be obtained in person or in writing. When voting, decisions shall be made via majority.

7. GUIDING PRINCIPLES
   7.1. The Council will ground its work on QI methodology (i.e., PDSA) and employ QI tools to understand and improve processes and outcomes.
   7.2. The Council's decisions will be data-driven and evidence-based, but it will also use and respect people's knowledge and experience.
   7.3. The Council will facilitate processes that will be transparent and inclusive.
   7.4. The Council will foster engagement and accountability within project teams.
   7.5. The Council will focus on learning and improvement over judgment and blame, and value prevention over correction.

8. MEETING SUMMARIES
   8.1. Meeting summaries are to be submitted within 7 days of each project's meeting.

9. RESPONSIBILITIES & WORK PLAN.
   9.1. Annually, Council members will update the work plan.
   9.2. The work plan will be guided by the following elements, delineated by NACCHO[2]:
      9.2.1. Leadership Commitment
      9.2.2. QI Infrastructure (including finalizing a QI Plan)
      9.2.3. Employee Empowerment and Commitment
      9.2.4. Customer Focus
      9.2.5. Teamwork and Collaboration (including actively participating in QI project)
      9.2.6. Continuous Process Improvement

10. While the Steering Committee is responsible for "Leadership Commitment", the Council holds responsibility for all other elements of the work plan.

[2] National Association of County & City Health Officials. (2012). Roadmap to a Culture of Quality Improvement. Retrieved from: http://qiroadmap.org/wp-content/uploads/2013/01/QIRoadmap.pdf

Work Plan

The goals & objectives below reflect modified themes & strategies from the Roadmap[iii], phase 2.

Work Plan (2017-2018)					Monitoring & Evaluation			
Goal (Theme/ Activity)	Objective	Measure & Target	Time	*	Persons Resp.	Progress	Actions Needed	Evaluation[E]
1 Leadership commitment *Communicate importance and value of QI.*	By Dec 31, 2016, leaders assess the current organizational culture.	75% of steering committee members complete QI culture assessment.	Q1	CS	QI Specialist To Admin Directors	COMPLETE Dec 2016	None	None
	By Dec 31, 2016, update culture of quality and future desired state in QI Plan.	QI plan with updated current and future state of quality.	Q1	S	**QI Specialist**	COMPLETE Dec 2016	None	None
	By Dec 31, 2016, set meeting to communicate to governing entities the urgency for and benefits of QI.	1 meeting set with PHS administration Directors for QI/PM meeting.	Q1	CS	**QI Specialist** To Admin Directors	COMPLETE Dec 2016	None	None
	By March 30, 2017, update work plan with proposed activities from each Roadmap theme.	Work plan objectives include Roadmap strategies.	Q1	M	All QI Council Members	COMPLETE May 2017	None	Lessons learned: Identify leader and deputy leaders at onset.
	By December 31, 2017, comm. QI activities to Dep. Secretary.	2+ updates at meetings	All	S	**QI Specialist**	Pending 11/??/17 COMPLETE 7/27/17 COMPLETE 4/20/17	Continue to provide regular updates to leadership.	Efficiencies gained: Flier was used at 7/27/17 that summarized latest updates. Use this flier to provide next updates in 11/17.
	By December 31, 2017, leaders dedicate additional human and/or financial resources to QI.	Survey findings from leaders that describe how they will commit resources to QI.	Q4	S M	Amber **Mallory** Maura Onyeka Sharein Karen QI Specialist	In progress	Request funding for Train-the-Trainer from leadership.	

Work Plan (2017-2018)					Monitoring & Evaluation			
Goal (Theme/ Activity)	Objective	Measure & Target	Time	*	Persons Resp.	Progress	Actions Needed	Evaluation[E]
	By December 31, 2017, leadership commits to requiring representation from all agencies to allow for interdisciplinary approach.	Dr. Haft states in writing all administrations are required to have representation in QI Council- administrations cannot opt out more than once consecutively.	Q4	S M	Dawn Rachel Reshma Amanda Kim QI Specialist	Pending	Create PPT slides for QTRLY leadership meeting that: 1) lists non-participating administrations; 2) Emphasizes importance of participation from each administration.	
2 Employee Empowerment and Commitment** *Identify QI Advocates*	By Mar 30, 2017, define key quality terms.	List of key quality terms in QI plan.	Q1	M	All QI Council Members	COMPLETE May 2017	None	Lesson learned: Consider adding QI Council roles and their definitions into key terms.
	By December 31, 2017, plan to offer Train-the-Trainer.	Contract with vendor Training date set	Q4	S M	Amber **Mallory** Maura Onyeka Sharein Karen QI Specialist	In progress	Ask LHDs if their QI contacts are interested in attending in-person "Train-the-Trainer" if already received basic QI training .	
	By October 31, 2017, identify QI points of contacts.	1 QI contact per county 1 list of QI contacts	Q3	S M	Amber **Mallory**	In progress	Email to local health officers	

Work Plan (2017-2018)					Monitoring & Evaluation			
Goal (Theme/ Activity)	Objective	Measure & Target	Time	*	Persons Resp.	Progress	Actions Needed	Evaluation[E]
					Maura Onyeka Sharein Karen QI Specialist		will request 1-2 QI contacts per jusisdiction	
3 QI Infrastructure *Institutionalize QI into structure.*	By January 30, 2017 select QI Council.	1+ Persons selected per administration and staffing level	Q1	CS	**QI Specialist** and Steering	COMPLETE 2/17	None	None
	By March 30, 2017, QI Council finalizes QI Plan and Work Plan.	1 QI Plan finalized 1 Work Plan finalized	Q1	M	All QI Council Members	COMPLETE May 2017	None	Lesson learned: When introducing work plan, more clearly emphasize difference between QI Plan and QI Projects.
	By December 31, 2017, QI Council drafts QI Council Charter.	1 QI Council charter final draft	Q4	M	All QI Council Members	Pending		
	By December 31, 2016, Off. of PM sets meeting for PM self-assessment.	1 meeting with PHS administration Directors for QI/PM meeting.	Q4	C	Ann Walsh	Pending		
	By December 31, 2017, update Work Plan each meeting.	1+ Work Plan update	Q4	S M	**QI Specialist** & All QI Council Members	PENDING 10/5/17 COMPLETE 7/27/17	None	
	By May 31, 2017, ensure QI Council is founded upon a QI plan that meets PHAB requirements.	PHAB Accreditation	Q2	S M	**QI Specialist** & All QI Council Members	COMPLETE	None	None
	By December 31, 2017, discuss how to continue QI Council activities into next year.	Date identified to develop 2018 work plan. Maintain accreditation	Q4	M	Dawn Rachel Reshma Amanda Kim	Pending		

Work Plan (2017-2018)					Monitoring & Evaluation			
Goal (Theme/ Activity)	Objective	Measure & Target	Time	*	Persons Resp.	Progress	Actions Needed	Evaluation[E]
4 Customer Service*** *Seek and use feedback from customers.*	By June 1, 2017, each Council member completes online "Customer Service" training.	100% completion of training by QI Council members	Q2	M	Robert Ann **Sharell** Liz	Pending	Need to follow up to ensure everyone has taken training.	
	By September 1, 2017, each Council member completes in person "Customer Service" training.	100% completion of training by QI Council members	Q3	S M	Robert Ann **Sharell** Liz QI Specialist	Not applicable	None	The in person training for this is no longer offered at request by the training services division. As a result, we are no longer pursuing this objective.
	By December 31, 2017, each project incorporates a customer service component.	100% of projects have customer service component	Q4	S M	Robert Ann **Sharell** Liz QI Specialist	Pending		
5 Teamwork and Collaboration** *Lead QI Projects*	By March 30, 2017, identify ideas for QI projects from each administration.	Documentation that describes and demonstrates project identification	Q1	M S	All QI Council Members	COMPLETE 2/2017	None	Lesson learned: Clarify differences between forms for: submitting ideas & applying for QI Council.
	By March 30, 2017, prioritize QI projects.	Documentation that describes and demonstrates project prioritization	Q1	M	All QI Council Members	COMPLETE 2/2017	None	None
	By March 30, 2017, produce one project charter per QI project.	1+ Project Charter/ QI Project	Q1	M	All QI Council Members	COMPLETE 5/2017	None	Efficiency: Identify fields that were unclear/ superfluous and fix.

Work Plan (2017-2018)					Monitoring & Evaluation			
Goal (Theme/ Activity)	Objective	Measure & Target	Time	*	Persons Resp.	Progress	Actions Needed	Evaluation[E]
	By December 31, 2017, produce meeting summary per meeting.	1+ "Meeting Summary"	Q4	S M	All QI Council Members	PENDING 10/2017 COMPLETE 7/2017 COMPLETE 5/2017 COMPLETE 2/2017		
	By December 31, 2017, each team produces 1+ Project Tracker	1+ Project Tracker per team	Q4	M	All QI Council Members	Pending 7/2017		
	By December 31, 2017, complete one QI project per team.	Each team completes QI project. Initiated, incomplete projects have transition plan 1 Story board – Program 1 Story board - Administrative	Q4	S M	QI Specialist Dawn Rachel Reshma Amanda Kim	Pending		
	By December 31, 2017, upload meeting summaries to electronic library.	Electronic library shows meeting summaries.	Q4	S	QI Specialist QI Project Leads	COMPLETE 7/2017 COMPLETE 5/2017	QI Project Leads need to upload any meeting agendas/summaries/ rosters to google drive.	
	By December 31, 2017, use 1+ method to share storyboards publicly.	Screenshot of storyboard shared publicly.	Q4	M	All QI Council Members	Pending		
	By December 31, 2017, update "technical assistance request" process to include identifying ideas for QI projects from each administration.	Number of projects identified/ administration Documentation that describes and demonstrates project identification	Q4	M	Dawn Rachel Reshma Amanda Kim	Pending	Create PPT slides for QTRLY leadership meeting that: 1) lists which	

Work Plan (2017-2018)					Monitoring & Evaluation			
Goal (Theme/ Activity)	Objective	Measure & Target	Time	*	Persons Resp.	Progress	Actions Needed	Evaluation[E]
							administrations submitted ideas; 2) lists which administrations had their idea selected; 3) Emphasizes importance of participation from each administration.	
6 Continuous Process Improvement* *Provide periodic training*	By March 30, 2017, QI Council explores and selects QI model.	1 model for selected (e.g., PDSA)	Q1	M	All QI Council Members	COMPLETE February 2017	None	None
	By December 31, 2017, collect evaluation for QI projects.	1 Evaluation per project	Q4	M	All QI Council Members	Pending		
	By December 31, 2017, produce one evaluation document for Work Plan.	1 Evaluation – Work Plan	Q4	S M	All QI Council Members & QI Specialist	Pending		
KEY	* Entity Responsible (C= Steering Committee, S= QI Specialist, M=Members) ** Overlaps with other theme/ goal *** No recommendations, draws from next phase							

[E] This work plan will be evaluated by examining each objective using the following questions:

- What is the progress towards achievement of target in Work Plan?
- What are efficiencies and effectiveness obtained?
- What were lessons learned?
- How was customer/stakeholder satisfaction?
- How might reports on progress be used to revise and update the QI plan?

Plan Sustainability Checklist

Developing systems to sustain the gains from your plan requires ongoing effort. Maintaining these systems assures that all of your hard work pays off in the long run. Use this checklist to assist you in sustaining the agency's Quality Improvement Plan (QI Plan). Each task includes activities that support achievement of the task.

- ❑ **We have a team** responsible for QI plan implementation, achievement of goals and objectives, and facilitating communication to leaders, staff, and clients about agency performance. Ideally, this will be a QI Council or other QI oversight body.
    - Who is/will be the QI process owner(s)?
    - What are their specific responsibilities in sustaining the QI plan?
- ❑ **Our senior leaders are involved in keeping everyone focused on improving performance**. They are knowledgeable about the QI plan and communicate about its importance and results of implementing the QI plan at staff meetings, as well as informally day-to-day.
    - What information is needed to keep leaders informed about the QI plan?
    - How will it be communicated? How often?
    - What will we ask leadership do to keep our agency focused on improving performance?
- ❑ **We make sure our systems and processes are independent of the people involved** by providing relevant ongoing training, making this training part of our new employee orientation, adding relevant roles and responsibilities to job descriptions, considering requirements in the hiring process, and cross-training staff for roles related to the QI plan.
    - What training is needed?
    - Who will assist the process owner with ensuring training needs are met?
    - What job descriptions and work plans need to be updated?
    - Who needs to be cross-trained for critical roles?
    - How will your hiring process be altered?
- ❑ **We create, adapt, or use existing tools** (i.e. checklists, visual aids, policies and procedures, etc.) to make it easier for everyone to follow the new procedures and systems we established through QI projects.
    - What tools should be created or adapted?
    - Who will create and adapt needed tools?
    - How will the information be communicated to staff?
- ❑ **We continuously monitor QI plan goals, objectives, and performance measures** in order to know for ourselves: "Are our QI projects working? Are we seeing improvements?" Once our targets are reached for one goal, we shift to an auditing mode (decreasing the frequency and quantity of data collected) so that data collection is easier to sustain. Then we address other goals, objectives, and performance measures in the QI plan.
    - What are the "vital few" measures that will be tracked? What data no longer needs to be collected?
    - How often will the data be collected (should be "just enough")?
    - Who will continue to collect the data?
    - How will the results be reported to management?
- ❑ **We celebrate our success with all of our staff**.
    - How will the successes be celebrated?
    - What are good milestones to celebrate the successes (e.g., six-month/one year anniversary, 100 days above goal, etc.)?
- ❑ **We communicate our improvements to our clients or stakeholders** to involve them in sustaining a focus on performance and improvements made through QI projects, and create additional accountability.
    - What will be communicated to our clients/customers?
    - How will the information be communicated?
    - Who will assist the process owner with developing communication materials?
    - When will the information be communicated?

Technical Assistance Request

1. What is your first and last name?
2. What is your email address?
3. Please select your administration.
4. The problem/idea I identified is part of a stable process. (Yes, No, I'm not sure).
5. There is the opportunity to effectively influence/ change the problem that I identified (Yes, No, I'm not sure).
6. There are measurable results to the problem/ idea that I identified (Yes, No, I'm not sure).
7. The problem/idea I identified is part of a required service: A) Mandate (legislative), B) Accreditation, C) Impacts core/foundational services, or D) tracked by State Health Improvement Process.
8. The problem/idea I identified requires the following resources: A) existing personnel, B) existing budget, or C) new personnel/ budget.
9. The problem/idea I identified has a public health impact.
10. The problem/idea I identified has a customer impact.
11. The idea I identified is sustainable—there will be a transition plan in place if needed.
12. Please describe your quality improvement project suggestion below.

Prioritization Matrix

How to Complete the Project Prioritization Matrix:

1. Write the project name.
2. Evaluate the project against the first criteria.
3. Based on how well the project fits that criteria, identify the project's score.
4. Multiply score by weight.
5. Write the resulting number, the "weighted value", into the box for that project & criteria.
6. Repeat steps 1-6 for each criteria.
7. Write the sum of that project's column in the corresponding "total project score" cell.
8. Repeat steps 1-8 for each project.

The project with the highest total project score is your top priority project. Learn more here: http://oqi.wisc.edu/resourcelibrary/uploads/resources/Project_Prioritization_Guide_v_1.pdf

Criteria		**Scoring values**	**Weight**	**Project A**	**Project B**	**Project C**
1	The project is PDSA ready: • Stable • Can be influenced • Measurable	0: none are true 3: one is true 6: two are true 9: all are true	5			
2	Required service/ product: • Mandate (legislative) • Accreditation/ Strategic Plan/ SHIP • Impacts core services	0: none are true 3: One is true 6: two are true 9: all are true	4			
3	Resources required • Existing personnel • Existing budget • New personnel/ budget	0: all are true 3: two are true 6: one is true 9: none are true	3			
4	Public health impact Risk mitigation? Health status improvement?	0: no impact on risk or health 3: Some risk mitigation OR health improvement 6: Much risk mitigation OR health improvement 9: Much risk mitigation AND health improvement	2			
5	Customer impact If offered, how would this affect the customer?	0: No impact 3: Some impact 6: Much impact 9: Significant impact	1			
6	Sustainability	0: Not sustainable 3: Sustainable with a lot of effort/ staff 6: Sustainable with little effort/ staff 9: Sustainable with no effort/ staff	1			
		Total project score →				

Project Packet

Worksheet 1: Project Charter

This "QI Team Charter" is your team's roadmap. The team charter will evolve over the course of your project, and you will not be able to complete the entire document before beginning your project. Complete as much as you can, revise it as you obtain more information. Save updated versions to chronicle your efforts.

Learn more from the source, here (page 27): https://www.mphiaccredandqi.org/wp-content/uploads/2013/12/2012_02_28_Guidebook_web_v2.pdf

1. Team Name:	2. Version:	3. Subject (Target Area):	
4. Problem/ Opportunity Statement:			
5. Team Sponsor:		6. Team Leader & Scribe:	
7. Team Members:		Role:	Administration:
8. Process Improvement Area:			
9. Current Aim Statement:			
10. Revised Aim Statement:			
11. Scope (Boundaries)/ Team Authority			
12. Customers (Internal and External)		13. Customer Needs Addressed:	
14. Success Measures (What does success look like?)			
15. Considerations (Assumptions/ Constraints/ Obstacles			
16. PDSA Timeline			Date:
PLAN			
DO			
STUDY			
ACT			
17. Meeting Frequency:			
18. Communication Plan (Who, How, and When):			
19. Stakeholders (Internal and External):			
20. Improvement Theories:			
If		Then	
If		Then	

Worksheet 2: Project Tracker

The health department must document implementation of quality improvement activities and the health department's application of its process improvement model. This document captures how a QI Project meets PHAB guidance for 9.2.2.

- Project Title: TBD
- Duration: TBD – TBD
- Date updated: TBD

#	PHAB measure	Action(s) Taken	Staff involved	Evaluation[E]
1	*how staff problem- solved and planned the improvement,*	*Staff utilized the improvement model, PDSA to:*		
2	*how staff selected the problem/process to address and described the improvement opportunity,*	*Tools and techniques:*		
3	*how they described the current process surrounding the identified improvement opportunity,*	*Tools and techniques:*		
4	*how they determined all possible causes of the problem and agreed on contributing factors and root cause(s),*	*Tools and techniques:*		
5	*how they developed a solution and action plan, including time-framed targets for improvement,*			
6	*what the staff did to implement the solution or process change,*	*Improvement practices and interventions:*		
7	*how staff reviewed and evaluated the result of the change, and how they reflected and acted on what they learned.*	*Data collection tools and analysis:*		
8	*Other activities and products that resulted from implementation of the plan*			

E This work plan will be evaluated by examining each objective using the following questions:

- What is the progress towards achievement of target in Work Plan?
- What are efficiencies and effectiveness obtained?
- What were lessons learned?
- How was customer/stakeholder satisfaction?
- How might reports on progress be used to revise and update the QI plan?

Worksheet 3: Storyboard

Quality Improvement Storyboard

Project Title: TEXT HERE
Organization: TEXT HERE
Team members: TEXT HERE
Learn more: dhmh.phsqualityimprovementcouncil@Maryland.gov or 410-767-7211

Plan

Identify an opportunity and plan for improvement

1. Get started.

Problem:
TEXT HERE

This problem was identified and prioritized because:
1. TEXT HERE
2. TEXT HERE
3. TEXT HERE

2. Assemble team.

Roles & responsibilities:

ROLE HERE:
- TEXT HERE
- TEXT HERE
- TEXT HERE

ROLE HERE:
- TEXT HERE
- TEXT HERE
- TEXT HERE

3. Examine current process.

IMAGE HERE

Internal and External Stakeholders:

Stakeholder:
TEXT HERE

Stakeholder:
TEXT HERE

Stakeholder:
TEXT HERE

Stakeholder:
TEXT HERE

4. Identify root causes.

IMAGE HERE

A major, actionable root cause includes:
- TEXT HERE

Other root causes include:
- TEXT HERE

5. Develop improvement theory.

If...
TEXT HERE

...then
TEXT HERE

Do

Test the theory for improvement.

6. Test the theory. Make change!

Staff implemented process changes by doing the following:

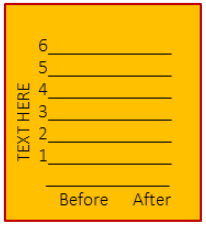
1. TEXT HERE
2. TEXT HERE

Study

Use data to review results.

7. Study the results.

Staff reviewed and evaluated the result of the change, and reflected on what they learned. A comparison of outcomes suggests that TEXT HERE.



Act

Standardize the improvement and establish future plans.

8. Adopt, adapt, or abandon.

We will "TEXT HERE" this improved process.

9. Establish future plans.

TEXT HERE

Communications Plan

Quality Improvement Council

Maryland Department of Health and Mental Hygiene
Public Health Services Division

2017-2018
Version 1.1 Draft
Last Updated: 7/31/17

Introduction

The Quality Improvement Council uses emerging and traditional communication channels to engage in a dialogue and further the reach of quality improvement. Quality improvement has the potential to produce public health processes that respond to community needs and improve population health (PHAB definition). This document is adapted from:

- https://www.aids.gov/pdf/communication-plan.pdf
- Maryland Responds Identity Kit

Staffing and implementation

The QI Specialist executes logistics and outlines operations. As members are interested and available, QI Council members will assist with communications logistics and operations. .Our communication channels tap into partners and governing entities such as:

- DHMH Office of Communications
- Local health department quality improvement programs
- National quality improvement listservs

Monitoring and Evaluation

Ongoing monitoring and evaluation (M&E) is an integral component of our overall strategy. The QI Council conducts process monitoring to determine the degree to which we meet our objectives. We evaluate each activity using the following questions:

1. Did we reach our intended audience?
2. Did we accomplish the task we set out to do?
3. Was there appropriate return on investment?
4. Does this incorporate our brand?

Future Directions

1. Quality improvement will be applied to improve on this communications plan where needed.
2. Quality improvement will be applied to improve upon our communication tasks where needed.
3. Feedback from the Quality Improvement Council will also be incorporated to improve this Plan.

The P.O.S.T. method

PEOPLE: Who are we trying to reach?

Our services target programs under the umbrella of Public Health Services, including:

- Controlled Substances
- Prevention and Health Promotion
- Local Health Departments
- Preparedness and Response
- Population Health
- Vital Statistics
- Laboratories
- Health Care Quality
- Anatomy
- Medical Examiners
- Chronic Hospitals

OBJECTIVES: What are we trying to accomplish?

The mission of this plan is to regularly communicate quality improvement activities conducted in the health department. The following objectives help us to meet the needs of our target audience:

1. Expand visibility of the practice of the Quality Improvement Council to Public Health Services.
2. Increase knowledge of quality improvement to Public Health Services.

STRATEGY: How do new and tradition tools support our objectives?

- To best meet our audiences' information needs, we use the following strategies: Disseminate, repurpose, and promote quality improvement information and encourage individuals to personalize and share information; this extends the reach of quality improvement messages to broader audiences and gives those messages peer-to-peer credibility.
- Serve as a catalyst to foster new, innovative collaborations by helping different administrations, PHS initiatives, DHMH initiatives, and other activities coordinate their communication efforts.

TECHNOLOGY: What are the most appropriate tools to use?

The Quality Improvement Council uses multiple communication vehicles and approaches to reach target audiences and accomplish our objectives. Through our communication strategy, we disseminate and promote a variety of information (see table, "Which tools do we use to disseminate information?").

Our primary focus is on tools and channels with the highest return on our investment and greatest insights into the needs of Public Health Services. See next section for detailed table. Our criteria for selecting these tools and channels are the following:

- Has a large number of critical mass individuals from our target audience;
- Responds to an expressed information need; and/or
- Provides a significant opportunity to engage with our audiences

Communication tools we use

We use some tools and channels on a secondary basis to communicate about selected pieces of information

Which tools do we use to disseminate information?	Knowledge (e.g., what is quality improvement, tools, news)	Council recruitment	Training announce-ments	Best practices (e.g., story boards)	Activities (progress reports, annual reports)
Tool					
PRIMARY FOCUS					
Website	✓	✓	✓	✓	✓
QI Advocate Listserv	✓	✓	✓	✓	✓
Council meeting	✓	✓	✓	✓	✓
PHS Directors Meeting	✓	✓	✓	✓	✓
Event/ Other Meeting	✓	✓	✓	✓	✓
Reports	✓			✓	✓
Email	✓	✓	✓	✓	✓
Phone call	✓	✓	✓		
SECONDARY FOCUS					
SHIP Newsletter	✓			✓	✓
Facebook	✓			✓	
Twitter	✓			✓	

Join the movement for quality improvement!

Learn more here: http://bit.ly/improvePH
Sign up for news, trainings, and best practices-- QI Advocate Listserv: http://bit.ly/Improve-Advocate
Apply for the QI Council: http://bit.ly/Improve-App17
Suggest a QI Project: http://bit.ly/Improve-Suggestion

Branding Guide

The branding guide serves as a resource to help promote and build awareness of the Quality Improvement Council.

Key messages

Message type	Message
Positioning statement	The Quality Improvement Council is a leadership development program that connects public health advocates with skills to build stronger public health systems. Our mission is to grow a culture of quality in Public Health Services.
Core messaging themes	How can we do better? Not all change is an improvement, but all improvements require change.
Tagline	Join the movement for quality improvement.

Color Palette

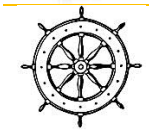
Color	Sample	HEX-Code	RGB	CMYK
Red		#B62025	182/32/37	19/100/100/11
Gold		#F5B82B	245/184/43	3/29/93/0
Black		#1F2125	31/33/37	75/68/61/71

Typography

Typefaces have unique characteristics that help communicate specific messages. The official typeface of the QI Council identify is Calibri Light.

Images

The QI Council uses a set of graphic marks to incite instant public recognition.

Image	Purpose
	Quality Improvement Advocates
	Quality Improvement Council
	Steering Committee (of Quality Improvement Council)

Action Plan (2017)

#	Date	Content/ Information	Target Audience	Tool	M&E (See below table)	Need QI?
1.	12/12/16	QI Orientation (Importance of QI, Where we are, QI Council)	Steering Committee (Administration Directors)	PHS Directors Meeting	1. Yes, almost all Directors were in attendance. 2. Yes 3. Yes 4. Yes	Yes- make more interactive
2.	12/16/16	QI Orientation (Importance of QI, Where we are, QI Council)	Steering Committee (Administration Directors)	Email – Sent by Chief of Staff	1. Unknown, do not know who opened email 2. Yes 3. Yes 4. Yes	No
3.	12/20/16	Start the conversation with staff about QI; QI Roadshows available to schedule	Steering Committee (Administration Directors)	Email – Sent by QI Specialist	1. Some (2/11 administrations scheduled) 2. In part 3. Yes 4. Yes	Yes – find better date to send email
4.	01/04/17	Reminder: Start the conversation with staff about QI; QI Roadshows available to schedule	Steering Committee (Administration Directors)	Email – Sent by QI Specialist	1. Some (4/11 administrations scheduled) 2. In part 3. Yes 4. Yes	No
5.	01/06/17	Reminder: Start the conversation with staff about QI; QI Roadshows available to schedule	Steering Committee (Administration Directors)	Phone call –by QI Specialist	1. Partially 2. Yes 3. Yes 4. Yes	Yes – Call sooner to allow for more time to schedule
6.	01/10/17	QI Orientation (Importance of QI, Where we are, QI Council)	SHIP Team	Event/ other meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
7.	01/11/17	QI Orientation (Importance of QI, Where we are, QI Council)	Office of Controlled Substances Administration	Event/ other meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
8.	01/11/17	QI Orientation (Importance of QI, Where we are, QI Council)	Prevention and Health Promotion Administration	Event/ other meeting	1. Yes, but future efforts could engage them further 2. Yes 3. Yes 4. Yes	Yes- Ask for more time in future so that QI examples can be shared

9.	01/11/17	QI Orientation (Importance of QI, Where we are, QI Council)	Health Officer Round Table	Event/ other meeting	1. Partially 2. Yes 3. Yes 4. Yes	Yes- Ask for more time in future so that QI examples can be shared
10	01/12/17	QI Orientation (Importance of QI, Where we are, QI Council)	Office of Preparedness and Response	Event/ other meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
11	01/17/17	PHS Leadership sends email about QI Council, Advocates, and ideas.	All administrations	Email/ Website	1. Partial 2. Partial 3. Yes 4. Yes	Yes - Some admin directors opted out
12	2/10/17	Letters of Acceptance go out	QI Council	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
13	2/20/17	QI Meeting - Inaugural	QI Council	Meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
14	2/21/17	QI Meeting – follow up and survey	QI Council	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
15	4/5/17	QI Advocate Listserv update	QI Council QI Advocates	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
16	5/1/17	QI Advocate Listserv update	QI Council QI Advocates	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
17	5/15/17	QI Training	QI Council QI Advocates Workforce Collaborative	Event/ Other Meeting	1. Yes 2. Yes 3. Yes 4. Yes	Include clear messaging to participants that they will work on QI project.
18	5/16/17	QI Meeting	QI Council	Council Meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
19	5/17/17	QI Training follow up & survey	QI Council QI Advocates Workforce Collaborative	Email	1. Yes 2. Yes 3. Yes 4. Yes	No

20	5/17/17	QI Meeting follow up & survey	QI Council	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
21	5/31/17	QI Plan published to website and announcement added to listserv update	All administrations	Website Email	1. Yes 2. Yes 3. Yes 4. Yes	No
22	6/7/17	QI Advocate Listserv update	QI Council QI Advocates	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
23	6/12/17	Technical assistance planning with Environmental Health	Prevention & Health Promotion administration	Event/ Other Meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
24	6/13/17	Technical assistance to Environmental Health (licensing status updates)	Prevention & Health Promotion administration	Event/ Other Meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
25	7/5/17	QI Advocate Listserv update	QI Council QI Advocates	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
26	7/20/17	QI Meeting	QI Council	Council Meeting	1. Yes 2. Yes 3. Yes 4. Yes	No
27	7/21/17	QI Meeting follow up & survey	QI Council	Email	1. Partial 2. Yes 3. Yes 4. Yes	No
28	7/27/17	Quarterly directors meeting – steering committee update on QI Council	All administration directors (Steering Committee)	PHS Directors Meeting	1. Partial 2. Yes 3. Yes 4. Yes	No
29	7/27/17	Communicate to QI Council that steering committee has been updated & their feedback	QI Council	Email	1. Yes 2. Yes 3. Yes 4. Yes	No
30	7/31/17	QI Plan published to website and announcement added to listserv update	All administrations	Website Email	1. Yes 2. Yes 3. Yes 4. Yes	No

Evaluation questions:

1. Did we reach our intended audience?
2. Did we accomplish the task we set out to do?
3. Was there appropriate return on investment?
4. Does this incorporate our brand?

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